AUTHORIZATION FOR AUTOPSY

Date: _____ Time: _____

I/WE request and authorize the South Carolina Department of Disabilities and Special Needs through its physicians to obtain an autopsy on the remains of _____ and **I/WE** authorize the removal and retention or use for diagnostic, scientific or therapeutic purposes of such organs, tissues and parts as such physicians and surgeons deem proper.

This authority is granted subject to the following restrictions: (if no restrictions write "NONE")

_____

_____

_____

The following special examination shall be made: (to be filled-in by the attending physician)

_____

_____

_____

I/WE wish the remains to be released to:

_____ _____ _____

(Name of Undertaking Establishment) (City) (State)

I/WE represent that **I AM/WE ARE** the _____ (relationship) of the deceased and entitled by law to control the disposition of the remains.

WITNESS:_____ SIGNED:_____

WITNESS:_____ SIGNED: _____

_____

(Name of Person Obtaining Authorization)

This form should be signed by the surviving spouse, and if there is no surviving spouse, then by the next of kin in accordance with the applicable state law. If the deceased was a minor

who lived with both parents, it is desirable that the authorization of both should be obtained.